GEAUGA COUNTY DRUG AND ALCOHOL CONSORTIUM

FOLLOW-UP TESTING AGREEMENT
ATTACHMENT A

I hereby agree that my continued employment is contingent upon successfully meeting the terms and conditions outlined in this agreement.

TESTING REQUIREMENTS

I, ____ hereby agree that I shall be
(Employee name)

Subject to __________________________________unannounced follow-up tests for the
(Number of Tests)

period of time from ______________________________to ___________________
(Month/year) (Month/year)

During this time, I understand that I must pass (test negative) said testing. Failure to report for testing, a refusal to test, or a positive random test, a post-accident test, or scheduled follow-up test will be a violation of this agreement and may result in disciplinary action up to and including dismissal.

Dated this _______________________________ Day of __________________, 20________

___________________________________ ___________________________________
Employee Signature Employer Authorized Representative

___________________________________ ___________________________________
Printed Employee Name Printed Employer Name

* Minimum of six (6) tests during the first twelve (12) month period. Follow-up testing not to exceed 60 months.

This form applies to entities that have a second chance policy

This form may apply to entities that have a zero tolerance policy. Refer to Zero Tolerance section, pages 12 – 13 of this policy for exception.

(5-1-14)